GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 18, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090016193
Investigation #:	2024A0123046
	Kasemeyer

Dear James Pilot:

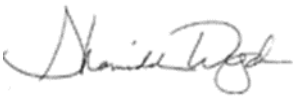
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 E. Genesee Ave.
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS090016193
Investigation #:	2024A0123046
Complaint Receipt Date:	06/27/2024
Investigation Initiation Date:	06/28/2024
Report Due Date:	08/26/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Kasemeyer
Facility Address:	5181 Kasemeyer Bay City, MI 48706
Facility Telephone #:	(989) 667-0470
Original Issuance Date:	02/01/1995
License Status:	REGULAR
Effective Date:	10/24/2022
Expiration Date:	10/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/25/2024, staff Megan Lotz left Resident A unchanged from 2:00pm-7:45pm. On 06/25/2024, Staff Lotz was consistently reminded to change the resident's brief. Resident A's room was observed to smell of urine. Resident A was completed saturated with urine and needed to have a full bed change.	Yes

III. METHODOLOGY

06/27/2024	Special Investigation Intake 2024A0123046
06/27/2024	APS Referral Information received regarding APS referral.
06/28/2024	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
07/15/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Megan Lotz.
07/15/2024	Contact - Telephone call received I interviewed Staff Lotz.
07/15/2024	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's case manager.
07/15/2024	Contact - Telephone call received I spoke with case manager Kim Jenks.
07/16/2024	Contact - Telephone call made I interviewed home manager Cassaundra Southgate.
07/16/2024	Contact - Document Received Requested documentation received via email.
07/17/2024	Exit Conference I spoke with administrator/designated person Tammy Unger.

ALLEGATION: On 06/25/2024, staff Megan Lotz left Resident A unchanged from 2:00pm-7:45pm. On 06/25/2024, Staff Lotz was consistently reminded to change the resident's brief. Resident A's room was observed to smell of urine. Resident A was completed saturated with urine and needed to have a full bed change.

INVESTIGATION: On 06/28/2024, I conducted an unannounced on-site at the facility. An attempt was made to interview Resident A. Resident A could not be interviewed due to their limited capacity. Resident A was at the kitchen table repeatedly asking staff to fix her a meal. Resident A appeared clean and appropriately dressed. No issues were noted.

During this on-site, I observed Resident A's room to be clean and odor free. Four other residents were observed during this on-site. They appeared clean and appropriately dressed. No issues were noted.

On 06/28/2024, I interviewed staff Maudena Scott at the facility. Staff Scott stated that on 06/25/2024, she started her shift at 2:00 pm. She stated that she did brief changes for her assigned residents. Staff Scott stated that she asked staff Megan Lotz if she had changed Resident A's brief, and if Staff Lotz needed help to let her know. Staff Scott stated that while passing medications, around 7:30 pm, Resident A's room smelled like ammonia. Staff Lotz was in Resident A's room. Staff Scott stated that she touched Resident A's bed and it was soaking wet. She stated that both Resident A and the bedding had to be changed, and that Resident A did not say anything. Staff Scott stated that she started Resident A's laundry. Staff Scott stated that she tried to guide Staff Lotz to check on Resident A, but from 2:00 pm to 8:00 pm, Resident A was not changed. Staff Scott stated that when she is assigned to Resident A, she does two to three brief changes during a shift. She stated that third shift staff that night had to wash Resident A's bed sheets multiple times to get the smell out.

A copy of Resident A's Bay Arenac Behavioral Health (BABH) *Nursing Guidelines* was obtained. It is written by BABH nurse Penny Griffus and is dated 05/16/2024. It states the following:

"[Resident A] will maintain healthy skin integrity with no open pressure sores/wounds over the course of the year. This is important due to recent skin breakdown, open wound on coccyx, hospital/rehab stay."

"[Resident A] should be repositioned every 2 hrs to help prevent skin breakdown. If not, this can result in skin breakdown. DO NOT LEAVE IN ANY ONE POSITION FOR LONGER THAN 2 HRS."

"Brief changes should be done at minimum every 2 hrs or sooner if soiled."

A copy of Resident A's *Assessment Plan for AFC Residents* dated 06/19/2024 under *Toileting* states that Resident A needs help due to incontinence, and it notes that brief changes are every two hours.

A copy of the *AFC Licensing Division- Incident/Accident Report* dated 06/25/2024 for 2:00 pm to 8:00 pm authored by home manager Cassaundra Southgate in summary states that Staff Scott reported that Staff Lotz left Resident A unchanged for the entire shift. Staff Scott went to pass meds at 7:45 pm, and Resident A's room smelled of urine, and Resident A's mattress was soaked. It was reported that it is believed that Resident A was not offered fluids/foods. Policy was reviewed with staff.

On 07/15/2024, I interviewed staff Megan Lotz via phone. Staff Lotz stated that on 06/25/2024, she worked from 2:00 pm to 8:00 pm. Staff Lotz stated that at the start of her shift she was presented with two write-ups. Staff Lotz checked on Resident A. Resident A was not wet. Staff Lotz then stated she started doing kitchen duties (i.e. cooking, serving the residents, and cleaning). Staff Lotz stated that after this, she checked Resident A again and noticed Resident A was wet, and everything else was wet as well (the bedsheets and pad). Staff Lotz stated that she asked Staff Scott for assistance to help change the sheets and padding. Staff Lotz stated that Resident A was dry at the end of the shift. She stated that she came in to work the next morning to do a medication check, was there for about two hours, then was told about the allegations regarding Resident A. Staff Lotz stated that Resident A was changed one time during this shift on 06/25/2024. Staff Lotz stated that Staff Scott said nothing to her about changing Resident A. Staff Lotz stated that there are only two residents in the home that require assistance with brief changes, and that she also assisted Staff Scott with Resident B's brief change that day. Staff Lotz denied that Resident A's room had an odor and stated that she has never seen Resident A urinate that much.

On 07/15/2024, I spoke with Resident A's Bay Arenac Behavioral Health case manager Kim Jenks via phone. Kim Jenks stated that she was aware of the allegations. She stated that staff are good to and good with Resident A. Kim Jenks stated that the goal is to get Resident A out of bed daily, and staff do encourage Resident A to get out of bed. Kim Jenks denied having any concerns about Resident A's care and thinks this is an isolated incident. Kim Jenks stated that this is a good home and the home manager addresses issues quickly.

On 07/16/2024, I interviewed home manager Cassaundra Southgate via phone. Staff Southgate confirmed that Resident A's brief has to be changed every two hours whether Resident A has soiled their brief or not. Staff Southgate stated that a sweaty moist brief can lead to Resident A having skin breakdown. Staff Southgate stated that Staff Lotz knows that Resident A is supposed to be changed every two hours, and when she and assistant home manager Autumn Blake questioned Staff Lotz as to why the brief changes were not done, Staff Lotz replied with "*I don't know*."

On 07/16/2024, I received requested documentation from Staff Southgate. Resident A's *Plan of Service Training* dated 05/16/2024 was received. Listed are all of the staff

names who signed verifying they were trained on Resident A's BABH *Nursing Plan* dated 05/16/2024. Staff Lotz's signature is listed and dated for 06/02/2024. A copy of Staff Megan Lotz's *Employee Corrective Action* dated 06/26/2024 notes Staff Lotz received a written warning for *Quality/Quantity of Work* and *Recipient Rights*. Under *Explain Corrective Action* it states "*Staff did not change [Resident A] entire shift @ 7:45p when Mo said we need to change [Resident A]- when did you do it last, due to smelling urine strongly upon entering room to do med pass. Consumer was completely soaked thru to mattress, very strong odor*." It also notes "[*Resident A] is on every 2 hr change/rotation schedule. Had past investigation regarding wound on buttocks w/ this consumer. This is not acceptable.*" Under *State the expectations of the employee* it states, "*To change consumer every 2 hours & rotate- offer fluids & food*."

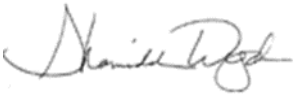
On 07/17/2024, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusion. Tammy Unger stated that staff will be in-serviced, Staff Scott and Staff Lotz will receive disciplinary action, and there will be re-training at the next staff meeting.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	On 06/28/2024, I conducted an unannounced on-site at the facility. I interviewed staff Maudena Scott. She stated that she tried to guide staff Megan Lotz through the shift to check on Resident A's brief, but around 7:30 pm Resident A's brief was soaked through. Resident A was observed during the on-site to be clean and appropriately dressed. Resident A's *Nursing Guidelines* dated 05/16/2024 notes that Resident A's brief changes are to be done at a minimum of every two hours or sooner if soiled. On 07/15/2024, I interviewed Staff Megan Lotz. She stated that Resident A's brief was changed one time during her shift on 06/25/2024.

	On 07/15/2024, I spoke with Bay Arenac Behavioral Health case manager Kim Jenks. She stated that she has no concerns about Resident A's care, and that this was an isolated incident. On 07/16/2024, I interviewed home manager Cassaundra Southgate. She stated confirmed that Resident A's brief has to be changed every two hours whether the brief is soiled or not due to a history of skin breakdown. There is a preponderance of evidence to substantiate a rule violation. Staff Lotz was interviewed and reported that Resident A was changed one time during second shift on 06/25/2024. Resident A's Nursing Plan states that Resident A brief is to be changed every two hours due to history of skin breakdown.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

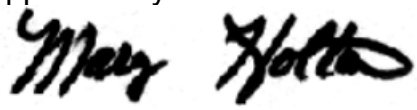
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



07/17/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



07/18/2024

Mary E. Holton Date
Area Manager